

# Colorado Medicine

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# COLORADO MEDICINE

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VOL. I.

DENVER, JUNE, 1904.

No. 8

## LEADING ARTICLES

### *EXTIRPATION OF THE LACRIMAL SAC FOR THE CURE OF DACYROCYSTITIS.*

In the whole field of ophthalmic surgery there is probably no class of cases which gives more annoyance to the surgeon and discomfort to the patient than those of inflammation and stricture of the lacrimal passages.

As usually treated they are practically never cured. The patient is subjected to the annoyance of tears flowing over the margin of his eyelids, producing in many cases an eczematous eruption on the cheek. The regurgitation of the contents of the sac extends the inflammation to the conjunctiva, setting up and keeping up a chronic conjunctivitis. A large proportion of cases are liable to repeated attacks of acute inflammation of the sac with infection of the surrounding tissues and the formation of an abscess.

The point of greatest importance, however, in the pathology of dacyrocyritis is, the danger of an accidental abrasion of the cornea becoming infected by the contents of the lacrimal passages, and thus producing a septic corneal ulcer with all its attendant perils.

Of the pathology of dacyrocyritis there is little or no difference of opinion. Stricture of the duct is admitted to be the chief, if not the sole cause of the affection. Stricture may be brought about by extension of inflammation from the nasal mucous membrane, the cicatrization of ulcers in, or in the neighborhood of the nasal duct, the presence of polypi or other tumors and by injury or disease of the neighboring bones.

We may, in general terms, divide the treatment of lacrimal obstruction and dacyrocyritis into two heads, (1) Conservative treatment (a) by small probes and (b) by large probes; and (2) Radical treatment by extirpation of the lacrimal sac. The probe treatment is usually supplemented by the injection of antiseptic and astringent solutions, and particularly is this true of those surgeons who use small probes through an intact canaliculus; amongst whom are such distinguished ophthalmologists as Von Mitchell, of Berlin, Schroeder, of St. Petersburg, and Adelheim, of Moscow. The majority of the European surgeons, however, first slit the canaliculus as a preliminary to probing, although it is exceptional for them to use large probes. Such is the practice of Fuchs, of Vienna, de Wecker, of Paris, Hansen Grut and Bjerrum, of Copenhagen, and Nordensen and Widmark, of Stockholm.

On the other hand the American school of ophthalmologists, influenced by the teachings of Williams, of Cincinnati, Noyes, of New York, and Theobald, of Baltimore, lays great stress on the importance of using large sounds in order thoroughly to dilate the stricture. There can be no question regarding the great superiority of this method of treatment as compared with the use of small probes.

The duration of treatment will extend to months and years, and there is usually a relapse even after an apparently excellent result has been attained. Frequently the patient, discouraged and weary of the long and painful course of treatment and hopeless of ever arriving at a permanent cure, is lost sight of.

The radical treatment of this affection consists in the removal of the lacrimal

sac. The following is the method of removing the sac advised by Rollet, of Lyons, France. An incision about 15 mm. long, but varying in accordance with the size of the tumor, is made, starting from the level of the internal palpebral ligament and descending at first perpendicularly and then being directed to the outer side. It thus describes a curve running parallel to that which is formed by the crest of the ascending process of the superior maxilla, which can be felt with the finger. The aponeurotic layer which covers the external wall of the sac is next incised. This is followed by a dissection of the fibrous layer, thereby exposing the anterior wall of the sac. The postero-internal portion of the periosteum and the external wall of the sac is next freed by means of a cutting raspator. The cupola of the sac is next disengaged and the whole sac cut away from its attachments at the level of the nasal duct. The last step is to curette the nasal duct. After the arrest of hemorrhage a flat dressing is applied, but neither drainage or sutures are used.

The scar is usually insignificant and hard to see. Suppuration is cured immediately the operation is performed, as well as all irritation and inflammation of the conjunctiva. The watering of the eye disappears with the cause of the hypersecretion, namely, lacrimal inflammation, and it is only when exposed to wind, dust, smoke, etc., that any epiphora is observed. In about 67 per cent. of cases no abnormal lacrimation exists.

Many ophthalmologists only resort to extirpation of the sac when other means have been fully tried in vain. On the other hand, Volckers, of Kiel, after performing over 500 extirpations, recommends the operation in all but the very mildest cases. He considers lacrimal obstruction to be a standing menace

to the safety of an eye amongst the laboring classes, since working men and women cannot submit to a long course of treatment, while they are the very people most prone to receive slight eye injuries.

Fuchs, of Vienna, resorts to removal of the sac under the following circumstances: (1) when extensive cicatricial contractions are present or when the nasal duct is completely obliterated; (2) when atony and dropsy of the sac are present; and (3) when the patient's circumstances forbid a prolonged course of treatment.

Most operators will find themselves in accord with the generalization of Herman Knapp, that extirpation is indicated in all those conditions in which "an important lacrimal disease can otherwise not so well or not at all be cured."

E. W. STEVENS.

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#### THE COLORADO MEDICAL LEGISLATIVE LEAGUE.

Those who always oppose the medical profession will oppose the Colorado Medical Legislative League. Those who think the profession should have no influence in the halls of legislation, and those who see no good in medical legislation they do not formulate, will have no use for it. Those who are indifferent to all but immediate private interests will be indifferent to it. Those who would rather complain of the attitude of the public toward the profession than do something to improve it, will hardly find this organization just what they want. But the mass of physicians in Colorado will give it their support.

If that support be active enough it will become an efficient instrument for good. The plan has been pretty generally explained to the physicians of the state. It has the hearty approval of the National Legislative Council, composed of prom-

inent members of the American Medical Association, who have been most actively interested in securing medical legislation in other states. It would unite all, laymen and doctors, without regard to sectarian designations, who desire to do something for the improvement of our laws bearing upon the practice of medicine, and upon the care of the public health.

It is such an unheard of thing for any particular class of men to advocate legislation that would not directly serve their own selfish interests; it is so totally different from the manufacturers lobbying for a tariff, or the labor unions for an eight hour law, that the mere assertion that the medical profession must be seeking some selfish end in any legislation they advocate is usually accepted without question.

Selfish interest does not lead doctors to urge general vaccination, or to study the causes of epidemics and methods for their prevention. But a governor seeking re-election finds that a law defining the practice of medicine and establishing an educational qualification for it, "has a tendency to build up under the protection of the state a trust or combination of certain schools or systems of medicine to the exclusion of all others equally meritorious." He seems confident that his suggestion of a medical trust will prevent objection to his ranking of any brazen quackery that styles itself a "school of medicine," as "equally meritorious" with the best scientific education of the age.

To secure good medical legislation we must have a broader organization than our medical societies; an organization that shall stand, not for a class, but for an idea. Medical legislation must be supported by a body, against whom the cry of selfish interest would be manifestly absurd.

EDWARD JACKSON.

## ORIGINAL PAPERS

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### THE BUELLOW METHOD OF DRAINAGE IN PYOPNEUMOTHORAX.

By H. B. WHITNEY, M. D., DENVER.

The development of febrile pyopneumothorax in a patient with pulmonary tuberculosis furnishes one of the most difficult problems with which we have to deal. On the one hand, if there is no surgical intervention the patient will probably waste gradually but steadily gives away from his continuous hectic. If, on the other hand, the radical operation for empyema is performed, the future of the patient is scarcely less hopeless and appalling.

Very probably, as in the case shown, the pneumothorax has been of considerable duration, having been accompanied at first by a simple sero-fibrinous effusion. The lungs, mediastinum and diaphragm have become therefore more or less fixed in their abnormal position; and when the enormous cavity is freely opened by the radical operation and the intrapleuritic pressure becomes atmospheric, there is but little tendency for the natural forces to fill in the space thus produced.

Fever may cease after the operation, and the immediate result may be fairly good. But the long and well-nigh interminable suppuration which follows; the annoyance, expense and uncleanliness of the daily dressings; the constant danger of secondary infections; the possibility of subsequent amyloid degenerations; the constant tendency to utter discouragement of both patient and physician; and finally the fact that a chronic suppuration is the very best that can be hoped for, while in many cases the operation is followed by a rapid decline—all these considerations explain why it is that many surgeons regard a pyopneumothorax as a *noli me tangere*.

Most afebrile cases should be let alone or, at most, be aspirated from time to time as the necessity may arise. In cases with fever most authorities advise the radical operation. Unverricht, however, in the new Deutsche Klinik am Eingange des Zwanzigsten Jahrhunderts, writes as follows: "Old cases of pneumothorax with excessive pus formation had better be left alone. A cure is here scarcely to be hoped for, since the lung has lost its elasticity and is no longer able to reach the chest wall. Hence a permanent suppuration is unavoidable, and it is usually better for the tragedy to come to a close behind the curtain of the external tissues."

The case which I wish to present to the society to-day, Mr. Carroll E., aged 24, came to Colorado with a rather extensive tuberculosis of the left lung. The general condition, however, was excellent, his weight being 159 pounds, and his temperature, which was at first 99.5 to 101, having become practically normal in two months. On January 1, 1903, he suddenly developed a pneumothorax of the affected side of the chest. After a few days of dyspnoea and high fever he became comparatively comfortable, and was soon able to go about with an average evening temperature under 100°. A considerable amount of serous fluid had formed in the pleura, but for over three months I made no operative interference. In the first place, because there was no urgent indication; then because I could not be sure that the pulmonary fistula had healed; and finally because I have much faith in the beneficial effect of pulmonary compression.

On April 6th, however, since the fluid had steadily increased, since the dyspnoea was now exceedingly troublesome, with slight cyanosis; and since the heart's action was now constantly rapid and tumultuous—being never below 120—I felt that a cautious series of aspirations was advisable.

I began with the withdrawal of 32 ounces of clear serum; and repeated this three times, at intervals of about 10 days. But the fluid of the last puncture was quite cloudy, and at a fifth operation on June 5th pure pus was found.

I will not pause to consider the cause of this purulent change. It may, of course, have been faulty technique. Considering, however, that every usual aseptic precaution was taken, I am more inclined to think that infection was through the pulmonary defect. However this may be, we were confronted with a very serious problem, and I was so averse to any further operative interference that I thought best to wait awhile, in the hope that the presumably tuberculous suppuration might be attended with little or no fever. For a week or two the temperature did go but little above 100°; but it soon began to rise and about one month after the first appearance of pus it went daily to between 101° and 102°. There had also been a loss of some 8 or 10 pounds in weight, and the necessity for interference could now no longer be doubted.

On July 1st, under ether, a Buelow drain was inserted through the eighth interspace in the left axilla. About three pints of pus was allowed to flow out at once, and 10 hours later another pint and a half was removed. The flow then temporarily ceased, or rather was reduced to the steady discharge which has continued ever since.

During the three or four days that the patient was in bed, the tube which was about three feet in length siphoned into a vessel underneath. Since then, while the patient has been up and about, the tube passes, as you see, through the clothing and into a small bottle which is carried in the hip pocket. You notice that the tube is fastened in place by tape and adhesive plaster, the immediate vicinity of the opening being protected by a bit of iodoform gauze. The tube is still, at the

end of three months, very snugly in place, and around it there is no evidence of either the entrance of air from without, nor the escape of pus from within. There is also but little irritation and practically no suppuration of the canal. Once a fortnight is as often as it need be dressed, and the patient has only to preserve the equilibrium of the bottle in his hip pocket.

At no time has there been any obstruction of the tube or interruption of the steady flow of pus. The quantity of daily discharge was at first in the neighborhood of four ounces; it now averages about two. The pus has always been odorless.

The effect of the operation on both the general condition and the chest has been extremely satisfactory. The temperature by the mouth fell at once to normal, and has practically remained so ever since. This, together with a gain in weight of 14 pounds (now 163), a corresponding improvement in appetite and a marked diminution of dyspnoea and palpitation, have brought the patient up to the full appearance of health which you have already remarked.

The local signs are especially hopeful as regards the future. The heart and mediastinum, from their displacement toward the right, have returned to a normal position. Indeed, the latter as you see, lies considerably beyond the median line towards the affected side. You notice a very perceptible depression of the upper region of the left chest, a condition which has developed wholly since the drainage was begun. There is still dulness over the lower left back, and some of course in front; since the patient has a considerable area of consolidation in the upper lobe. But fairly good respiration is to be heard throughout the left front and back. While it is impossible to determine the present size of the pus cavity, it is certain that the lung has expanded very materially, and that the cavity is no longer of anything like its former extent.

This method of drainage would seem to be especially applicable to pyopneumothorax, as contrasted with many of the usual forms of empyema; tho in these also, as Ingalls and others have already claimed, it is probable that the method is not used as often as it should be. The siphon drainage maintains a constant negative pressure—a suction in other words—in the pleural cavity. It must, therefore, favor the expansion of the lung and the centripetal movement of the diaphragm, mediastinum and chest wall, which are nature's chief methods of filling the pus cavity. It was the notion that even the partial accomplishment of this result and the measurable fixation of the parts, which would probably follow even the temporary induction of siphon drainage, would be an enormous gain over present conditions, which led me to try the Buelow method. It seemed to me there was nothing too lose in so doing, since at any time the siphon drainage could easily be supplemented by the radical operation.

Three months have now elapsed, siphonage is still perfect, and it is probable that the steady contraction of the pus cavity is still going on. How long this will continue I do not know, in my lack of any previous experience with siphon drainage in similar cases. If the tube does not become too loose there would seem to be no reason to substitute open drainage for months, to say the least; and a larger tube might be inserted at any time, if necessary, through a larger canula. If complete cure does not result finally, an Estlander could then be done, under far more favorable conditions than are often presented in such cases.

A word in conclusion about the method itself: Under general or possibly local anesthesia, a trochar is thrust through the intercostal space into the chest. Ingalls has recommended a special flat trochar which permits the introduction of a

double tube,  $3/16$  of an inch in diameter. Since irrigation is now seldom practised, it seems to me that a large single tube is to be preferred; and I have therefore made use of a horse trochar having a diameter of  $5/16$  of an inch. Either a long tube may be inserted, like that in the case shown, or an ordinary soft rubber catheter to which a long external tube is easily attached. After insertion of the tube for several inches, care being taken to note its exact length, the canula is withdrawn, leaving the tube firmly grasped by the tissues of the thoracic wall. A small iodofrom gauze dressing is then fastened in place by adhesive plaster, and any possibility of escape of the tube may be prevented by a couple of loops of tape which are attached to the tube at its exit by winding with a narrow strip of plaster and are fastened by safety pins to strips of adhesive plaster encircling the chest. The distal end of the drain is then immersed in an antiseptic solution contained in a jar or bottle, to the mouth of which it must of course be firmly fastened. The slight attention which this bottle requires is surely a great improvement over the usual daily dressing of an open fistula.

#### Discussion.

Dr. Powers: Mr. President and Members of the Society—I am greatly pleased with the case which Dr. Whitney shows. I chanced to happen into the operating room at St. Luke's Hospital when he was doing the operation, and I am delighted with the result. I know of nothing more disagreeable for the surgeon to undertake than the cure of a case which has a tubercular pneumopyothorax. We have hitherto been proceeding about this way: When fever comes on we resect a rib and put in a tube; the lung in the majority of cases does not tend to come down; perhaps the diaphragm rises a little, perhaps the lung comes over a little from the other side, the chest wall may fall in a little; but at the end of six months or a year we still have an enormous cavity remaining. Then we begin taking out ribs, doing Estlander operations. Occasionally, but not often, a cure follows, particularly with an encapsulated empyema. I am sure that Dr.

Whitney's patient is at this time in far better condition than he would be if he had gone through the ordinary rib resections.

Dr. Van Meter: I wish to add to Dr. Whitney's paper an assertion that I saw a case treated more after Ingall's method with a double tube and the long tube attached to the bottle after the Buelow method. After two months the lung expanded completely and the discharge stopped entirely; and so far as the physical examination is concerned I do not think, further than the operating wound, it would be possible to detect that there had been a pyothorax of a pint and a half in quantity at the time of the operation.

The President: How long had that existed?

Dr. Van Meter: It followed a non-tubercular case. It was a pyothorax that followed a frank pneumonia. The patient, six or seven months after the operation, had no temperature, no cough and no material evidence of pyothorax.

Discussion closed by Dr. Whitney: I want to say what Dr. Powers says. I said nothing in my paper about an ordinary empyema. I had no thought of ordinary empyema. I did say that it is a question whether the Buelow drainage should not be used oftener than it is. I think perhaps that is a matter for experiment and trial. Ingall's has used it in something like eighty cases, and with a very large percentage of recoveries, apparently very satisfactory throughout. In my paper I referred to ordinary cases of pyothorax, not to ordinary cases of empyema. In the latter I still prefer the radical operation. Dr. Van Meter spoke of a case cured in three months. I once had a case of empyema following a frank pneumonia in which I did the radical operation, which was well in ten days, when the tube was out of the lung and there was no further pus in the cavity. It is only for this particular form of pyothorax, pneumopyothorax in tubercular cases, that I am enthusiastic at the present moment over the result with the Buelow method of drainage. I believe it should be used, or tried at all events, in the future much more frequently than it has been in the past.

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#### THE FIRST APPENDECTOMY.

By W. W. GRANT, M. D., DENVER.

The most complete bibliography of this subject is by Dr. Merrill Ricketts, of Cin-

cinnati. These investigations show that the following case antedates all others by more than two years.

When I operated in January, 1885, I could find no antecedent or contemporary history of such a case, and when first reported in 1892, the literature on the subject was still brief, and yet I did not then feel like claiming it as the first. But now, with the lapse of time, and the enormous literature at hand, I can but regard the claim as justifiable.

Manley, of New York, in the New York Medical Record, July 19, 1902, reproduces the classic article of Melier, written in 1827 on disease of the appendix, with report of eight cases. He credits a contemporary friend, Villermay, with being the first to direct the attention of the profession to disease of this organ. In the same article it is stated that Dupuytren, the celebrated surgeon, on March 14, 1814, opened an appendiceal abscess in the iliac fossa in one of the cases reported above, probably the first to operate for this condition. But there is no intimation that he knew anything of the pathology, although it was a tuberculosis subject who suffered four years. The other seven cases all died in a few days or week, and the pathological condition was demonstrated by a post-mortem in every case.

The only allusion to surgical treatment in this monograph is in these words: "If it were possible to establish an early and definite diagnosis in well circumscribed cases, one can conceive of the possibility of relieving them by an operation. No doubt this day will come."

The prophecy is fulfilled, and much more fully than he anticipated, for he is not a wise surgeon who confines operations to "well circumscribed cases."

The first published article on perforation of the appendix was by Fitz, in the

October issue, 1886, of the American Journal of the Medical Sciences, while my diagnosis of perforation was made in January, 1883, and the operation for its extirpation in January, 1885.

Miss M. H. G., aged twenty-two, school teacher, Davenport, Ia. A partial report of this case is published in the transactions of the Colorado State Medical Society for 1892. I have been requested to make a complete report of the case, which I now do.

In the early fall of 1882, the patient was taken with symptoms now known to be common to appendicitis. The attending physician did not understand the case. An abscess formed; no operation was suggested, and, fortunately, it opened in a safe place, in the right groin just beneath Poupart's ligament. My notes and visiting list show that I first saw the case in the latter part of December, 1882. The discharge was not now profuse, but purulent, with evident liquid fecal material. My diagnosis was perityphilitic abscess from perforation of the appendix. While the point of exit was suggestive of psoas abscess, yet the localized tenderness and history impressed me strongly with the diagnosis given.

She was living with her mother, brother and sister in a modest frame house. In this house four operations were performed on this patient, two of them sections, on an improvised kitchen table, using every precaution to secure cleanliness. Early in January, 1883, I operated, laying open the fistulous tract in the iliac fossa quite freely. Did not find the appendix which I supposed was partly or wholly excluded from the peritoneal cavity by adhesions. I feared to open the peritoneal cavity on account of the danger of extravasation and peritonitis. The wound was packed with iodoform gauze. In a short time a prune seed, three-quarters of an inch

long, was found in the wound, which tended to confirm my opinion that it was a case of perforation of the appendix, and that the disease originated in this organ. The wound did not heal, and discharged chiefly from now on liquid fecal matter. The patient was out on crutches in a few weeks, and the wound treated by irrigation and drainage with iodoform gauze and rubber tubes for the entire year of 1883, hoping that these measures would aid or induce healing of the intestinal perforation but I was disappointed, and now suggested laparotomy and removal of the appendix. But I was not then able to give a precedent or authority, and had to rely on the failure of other methods to justify a radical departure. I was obliged to continue the same methods until May 14, 1884, when Prof. Edmund Andrews, of Chicago, came to Davenport to consult with me in the case. I told him my proposition to open the abdomen and remove the appendix. He thought the diagnosis correct, but declined to sanction the operation on account of the "great danger" and believed it unnecessary. He recommended instead a counter opening in the loin, connected with the interior, so as to secure more perfect drainage. By this method he thought contraction and cicatrization would close the intestinal fistula. My experience gave me no confidence in it, but with his assistance I performed the operation immediately, and connected both wounds posterior to the cecum, and drained with tubes for six months with no better success than formerly. The patient, worn out with failure and deferred hope, now gave me unlimited discretion to perform the operation I had urged for a year: so on January 4, 1885, on the same table and in the same room previously used, aided by Drs. W. D. Middleton and C. H. Preston, of Davenport, I deliberately opened the abdomen

over the cecum rather perpendicular than oblique or parallel to Poupart's ligament. The anterior surface of the cecum was not adherent, but mottled and its walls thickened, showing the effects of much past inflammation. The caput coli was drawn into the wound, as well as firm adhesions about the appendix would permit. Two fingers were inserted in search of the appendix. The entire organ was found excluded by firm adhesions from the peritoneal cavity. The examination indicated that it was retrocecal and pointed outward. I did not break up the intra peritoneal adhesions for fear that fecal extravasation would infect the peritoneum at the time, or immediately following the operation, and prove fatal, so I proceeded as follows:

With the finger and handle of the scalpel I worked down on the outer side of the cecum, which was adherent, keeping two fingers of the other hand in the peritoneal cavity at the base of the appendix as a guide. I made for this point, and soon found the base of the appendix. With an aneurism needle I passed a silk ligature around it close to the cecum, and severed the appendix. I left the severed organ firmly imbedded in adhesions in the iliac fossa, knowing that it could do no further harm, and that I might cause fatal peritonitis by extravasation in breaking up the extensive adhesions in this the most dependent part of the wound. With our limited knowledge at that time in dealing with the stump, I think it was justifiable and perhaps a wise precaution. I closed the larger part of the wound and drained from the stump with iodoform gauze.

The patient showed no temperature and progressed as favorably as any I ever witnessed. When the gauze was removed on the eighth day I noticed the same evidence of fecal matter which I had so long observed, and proved that the liga-

ture had not closed the lumen, as I had hoped. I was disappointed, but still trusted it might now close in a few months without further operation. Of course, in a similar case, a few years later, we would have treated the stump differently.

On May 12, 1885, the patient was put on the operating table for the fourth time. (This part of the history was not included in the first published report.) My effort was now to close the stump fistula, so a second laparotomy was performed. All adhesions involving cecum and stump of the appendix were broken up, and the gut brought well into the wound. The stump was inverted, and two rows of Lembert silk sutures inserted. An iodoform strip of gauze drained from the stump. Operation unsuccessful, as I feared, because of the unhealthy condition of the peritoneum involved in the sutures.

The patient recovered promptly from the operation, and in a few weeks was walking with the use of a stick. An abdominal belt with a compress over the fistulous opening was used steadily. Not long after this the patient accepted a position as bookkeeper in an office in Fargo, S. D. No further effort was made to close the fistula for the present. I moved to Denver in January, 1890; the latter part of January, 1901, I received a letter from the patient saying: "If you think you can now close up the opening, I will come to Denver at once." I replied favorably, and she came promptly and was sent to St. Luke's Hospital, where, on January 26, 1892, I performed the third laparotomy; all adhesions were severed, and the cecum brought out of the wound. The opening in the stump, which readily admitted the index finger, and was practically an artificial anus, was closed in the following manner: I resected the mucous, muscular and serous coats of the bowel to the depth of a quarter of an

inch. The mucous membrane was now closed separately by a running stitch of chromicised cat gut. The muscular and serous coats were now sewed together in the same way. This line was now inverted, and Lembert silk stitches inserted. Finally these were turned in and shut up by a running stitch of chromicised cat gut. She recovered promptly, and the operation was entirely successful. She is now living in Minneapolis, Minn. In a letter from the patient dated February 23, 1904, she states that she has been well since the last operation in 1892, except from la grippe last fall: "I am certainly strong, and have worked very hard this winter."

This patient submitted to five operations: The first January, 1883, the second May 14, 1884, the lumbar incision for drainage suggested by Prof. Andrews. Then followed the first laparotomy with the excision of the appendix January 4, 1885, the second May 12, 1885, and the third and final on January 26, 1892, which was successful and permanent.

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#### PERFORATING ULCER OF STOMACH.—OPERATION.—RECOVERY.\*

BY CHARLES A. POWERS, M. D.,  
DENVER.

*Clinical History.* The patient, a young man of twenty-five years, was first seen in consultation with Dr. J. E. Kinney at 6:30 p. m., on Tuesday, December 8, 1903. He gave a history of "stomach trouble" extending over several years. His first attack of severe gastric pain was in Leadville in the summer of 1901, when he was ill for several days. In December, 1902, he again had severe gastric disturbance, and this recurred in February, 1903, and again in Au-

\*Read before the Medical Society of the City and County of Denver, March 1, 1904.

gust, 1903. In November, 1903, he had a gastric hemorrhage clinically and microscopically recognized by Dr. Kinney who made a diagnosis of gastric ulcer and kept him in bed for two weeks. His convalescence was uneventful.

On Sunday, December 6, while lying quietly on his bed at 5 o'clock in the afternoon, he was seized with sudden, violent and agonizing pains in the epigastrium. He did not vomit. The pains tended to shoot toward the right chest and right shoulder. Dr. Kinney being out of town, his associate, Dr. Canby, was sent for and attended him until the return of Dr. Kinney, on the evening of December 8. During this period the pain was so severe as to require a moderate amount of morphin. The pulse averaged from 116 to 123, the temperature about  $100^{\circ}$ . It was impossible to make a diagnosis. Dr. Canby's management was judicious.

Immediately upon his return to town, Dr. Kinney assumed the care of the case, and I saw the patient with him directly afterward. This was at 7 p. m., on December 8, a little over forty-eight hours after the onset. At this time the pulse was 120 and of fair quality, the temperature  $100\frac{1}{2}^{\circ}$ . The patient's face was dull and pinched, the lips were dry. There had been no vomiting, no passage of gas. The patient complained of a severe, dull, constant pain in the region of the stomach; this was deep, and tended to shoot toward the liver, right chest and right shoulder. The abdomen was moderately distended and tympanitic. It was hard and rigid throughout, quite tender in the epigastrium but fairly tender all over. No tumor could be discovered, there were no special symptoms at or near the seat of the appendix.

A diagnosis of probable perforation of the stomach\* was made and operation delayed. It was some 50 hours after per-

foration and delay seemed to both Dr. Kinney and me wiser than operation. The patient was ordered rectal nutrition, strychnia and spartein hypodermically. Nothing to be given by mouth, the bowels to be moved by turpentine, glycerin and epsom salts enema. Codein for pain.

December 9. The patient seems a little better. The purgative enema brought away a great deal of gas and small bowel movement. The pain is rather less. When asked to locate it the patient presses a little to the right of the median line and above the navel, and says: "It is somewhere deep in there, and around the lower, right ribs." The abdomen is less distended and less tender except in the right upper quadrant. The urine is negative.

December 10. The abdomen is pretty soft except in the upper, right quadrant, where it is still hard. Here it is tender over a diffuse area. It is impossible to locate the exact point of tenderness, nor can any tumor be made out. The condition does not seem to be appendiceal nor does it seem to be of the gall bladder, liver or chest. The original diagnosis stands. The patient has not vomited. He has had no chill. He sweats a little around the head. Rectal enemata bring away large amounts of gas. The management is not changed. He has nothing by the mouth, rectal nutrition is kept up. He has moderate stimulation with enough codein to keep down the pain. The pulse runs from 80 to 90, the temperature is normal in the morning, reaching  $100^{\circ}$  or a little over at night. Operation does not as yet seem wise.

During the next few days the condition continued about the same except that the patient lost markedly in weight while the abdominal pain and tenderness seemed to centralize below and to the left of the middle of the liver. On December 15,

\*Possibility of perforation of the duodenum was considered.

nine days after the onset of the condition, a deep, resistant, tender swelling about the size of a child's fist was made out below the tenth costal cartilage on the right side. It does not seem to be near the surface. In view of the pulse and temperature and the continued pain and tenderness it had for some days seemed probable that a deep abscess was forming, and the policy of delay was continued. At this time further delay was made in the hope that the abscess might tend to approach the surface and that it might be opened without going through the free peritoneal cavity. The patient had restless nights, and was losing flesh pretty fast.

December 16. The mass on the right side is larger and better defined. It is still deep. The pulse runs from 84 to 90, and the evening temperature is about  $100^{\circ}$ .

December 17. The swelling has increased markedly during the past twenty-four hours. To-day it is as large as a man's fist, and dull on percussion over an area of  $2\frac{1}{2}$  inches by 3 inches in diameter below the liver in the nipple line. It seems wise to operate now.

*Operation.* At St. Luke's Hospital, at 9 a. m., on December 17, 11 days after the onset of the disease. Gas and ether administered by Dr. Kinney. A  $2\frac{1}{2}$  inch incision over the middle of the dull area, just below the costal cartilage in the nipple line, opened into a foul cavity containing some three pints of pus. The finger introduced into this could not be swept far enough to find the inner wall. The liver was felt above, and the finger could be swept between it and the diaphragm. The cavity was limited below by adherent intestines. A free, dependent, posterior incision was made for drainage, the cavity gently irrigated and a drainage tube an inch in diameter run

through. Time of operation, 20 minutes, patient's condition good at close.

The subsequent course was smooth. The temperature came to normal and stayed there. Nothing was given by the mouth until five days after the operation. This was sixteen days after the onset of the disease, and the patient was greatly emaciated. At this time a little broth was cautiously given; stomach feeding was gradually increased, and in ten days the patient was on fairly good diet. He gained in flesh and strength pretty fast. The large abscess cavity closed rapidly. On January 5 it was nearly healed, on February 1 it was entirely healed. The patient is before you and those caring to do so can examine him. He has gained much in flesh, he now weighs 145 pounds, which is 18 pounds more than before this illness. Dr. Kinney finds stomach splashing and other symptoms of a lack of stomach power, and it seems probable that a gastro-enterostomy may be necessary later.

This case is in no way set forth as advocating delay in operating in perforating ulcer of the stomach. When seen immediately after the perforation the surgeon, on making a diagnosis, should submit the patient to the speediest operation possible. In this case very early diagnosis was not possible. At the end of fifty hours the abdomen was distended and rigid and the local symptoms deep and obscure. I think operation at that time would probably have killed the young man. The Ochsner treatment permitted the development of a "safe" abscess, coming forward and to the right from behind the stomach, as the perforation was probably a posterior one. Each case must be judged individually and the important matter of the *time* of operation selected according to the best judgment of the physician and surgeon in attendance.

*ABORTIONS IN GENERAL PRACTICE.\**

By A. N. MOODY, M. D., FOWLER.

Why the regrettable frequency of interrupted pregnancies? Does it mean pathological conditions, an alarming ignorance as to the hygienic precautions necessary to carry a fetus to its perfect development, or does the human mother sometimes begrudge her anticipated offspring its demands of fostering care?

That the causing of an abortion is legally criminal is well known. Society frowns on it, yet allows it. It would seem that this great inroad on human possibilities would arouse a greater interest than it does. But so common are these fatalities, so entirely expected by possibly the great majority of women, that their happening only arouses the attention that their immediate inconvenience occasions.

Before passing from the ethical point of view it might be said that physicians stand closest to its solution. Are doctors so lowered financially that they must cunningly encourage this seemingly remunerative practice? Are they so disinterested in their patients' future normal health that they will fail to warn them of this particular source of danger? Are they so unscientific that they will laud asepsis and antiseptics, and yet not only forget to urge the prophylactic measures necessary to the continuance of the pregnant state, but actually bestir the forces that kill? Statistics would seem to show this. It is probable that not an increase of penalty for the abetting of this crime, not even the proclaiming abroad of the disastrous effects on the mother's health, but only the education of a keener perception of that higher law—even the Sixth Commandment, "Thou shalt not kill," will stamp out this nefarious custom. And until the profession becomes cleaner morally and spiritually as well as surgically its attitude will mean little.

Some of the more common causes of miscarriage are violent exercise, injuries, as falls or accidents of any kind, nervous diseases or nervous disposition together with exciting conditions, pelvic congestion from whatever cause, uncontrollable vomiting, eclampsia or other convulsions, mal-positions of the uterus, and many other conditions that might be enumerated.

As to diagnosis, there is at times some little difficulty. The clinical phenomena of hemorrhage, pain, and the expulsion of more or less characteristic parts of the ovum are seldom typical. There may be little pain, slight hemorrhage; and the clots together with the ovum, if this has been passed, destroyed. Then again the process may not be complete and the history of the case uncertain. First, it may be best to try to determine as to whether the woman is pregnant. Is there a history of suppressed menstruation? Has she been exposed to impregnation, and have there been the usual signs of pregnancy? This much history affirmed, together with the discovery of a patulous os and hemorrhage, would certainly suggest an abortion. The possibility of its being an effort of the uterus to expel a polypoid tumor or a placenta previa could soon be proven or excluded.

It being established that an abortion is threatening, it becomes necessary to, if possible, determine as to whether it is inevitable. With persistent hemorrhage it will usually occur. All the more likely is this if the cervix is soft and the os dilated sufficiently to admit the detection of a presenting ovum. Doubtless many of you could cite cases to disprove this. One recently at hand is such an one. This woman was about forty years of age and pregnant for the first time. As she was of the class—Dane—that depend more or less on neighborhood women for a full term delivery, and much less

expect to call in a physician for a "mis-hap," so common among the hard-working class, it may be readily inferred I was not called until it got to be an emergency affair. I found her suffering severe "bearing down" pains and quite fearful lest she might have lost blood enough to be serious. The os was well dilated but rather rigid. The ovum was readily detected. Yet with an average dose of morphin the pain was stopped and the event tided over.

Cases have been reported in which more or less decidua has been expelled, and yet the pregnancy has gone on. Even liquor amnii has been resupplied after the rupture of the membranes. That the dead foetus may be retained almost indefinitely is well known. Yet with a persistent hemorrhage, a soft dilated os, considerable pain, and especially the expulsion of portions of the ovum it may be fairly safe to pronounce abortion inevitable.

A diagnosis having been made, it is important to decide as to whether a part or the whole of the uterine contents have been expelled. There should be a careful examination of the discharges. The clots may be floated in water and carefully disintegrated to discover if possible any membrane or the ovum. This is, of course, more necessary in the early months of pregnancy. A digital exploration of the uterine cavity is most satisfactory if such can be made. Often under ordinary circumstances, with the uterus high up, and an anesthetic hardly practical, this is not an easy thing to accomplish. Yet a patulous os may admit the detection of more or less deciduous membrane and often the still adherent placenta. If all has been expelled—even though the discharges may not show complete evidence—the uterus will generally be firmly contracted, os small, and a digital examination of the uterus difficult. I

recall a case which the woman, and an officious neighbor woman, were sure was a complete miscarriage. Both had had experience, and both were honest in their avowals that not only a fetus, but also the placenta had been expelled. These had been destroyed. An examination seemed to confirm their assertions. The call was sent in merely because they feared some septic trouble might develop. On inquiry it was found that more than an ounce of ergot had been taken. As a precaution the vagina was packed and the ergot ordered stopped. In forty-eight hours a second call easily demonstrated a placenta that was soon delivered. It was merely a case with imperfect history, and like many others, proved the necessity of being suspicious until unhampered nature was given a chance.

The possibility of a tubal pregnancy simulating abortion must not be forgotten. A careful examination, together with the pain characteristic of that condition, should clear up this question.

As to prognosis, if the physician alone has had to do with the case, sepsis should rarely result. This, of course, applies only in an innocent abortion. Yet it is sometimes true that deciduous masses may be retained which at times decompose and cause septicemia. Hemorrhage is the most to be feared of immediate dangers. The prognosis may be said to depend in great part on the kind and efficiency of the treatment of the case.

It is to be deplored that our schools so often send out students well nigh ignorant of the accepted details of treatment of just this class of work. To be sure all learn, or at least have an opportunity to do so, more or less perfectly. Fortunate is he who has a natural aptitude, and perhaps more fortunate if nature is so kind as to need little assistance. So it is with no feeling of wasting your time that some of the general methods

of treatment are outlined. In the way of prophylaxis any conditions favoring the premature expulsion of the ovum should, if possible, be overcome. A quiet life is to be encouraged. A plain but nutritious diet should be given. Especially excesses of any kind should be avoided at the time corresponding to the menstrual periods. General diseases need careful treatment. In this connection a recent case of nausea which threatened causing an abortion may be of worth. In former pregnancies this woman had been an extreme sufferer from vomiting. No remedies had seemed to give much relief. Some two or three years ago this condition had been such, after careful and prolonged local and general treatment, that an abortion had been produced by her attending physician. So it was with a good deal of skepticism that I began treatment for the same trouble. She was some two months pregnant and greatly reduced by vomiting. She had thought from her former experience that drugs were of little worth to her. And I, after a trial of a greater part of the favorite remedies, also came to the same conclusion. Finally an effervescent magnesia sulphate was given in considerable and frequently repeated doses. She quickly improved and by often resorting to this line of treatment has now comfortably reached her eighth month and bids fair to have a normal delivery.

As to treatment of threatened abortion —general physical and mental rest are necessary. The nerve sedatives may be employed. Viburnum Prunifolium in the form of the fluid extract may be given in dram doses three times a day. But it would seem that morphin hypodermically is of the most value. If the abortion becomes inevitable the absolute rest is no longer necessary and the sedatives should be stopped. A severe hemorrhage with a small os, may be controlled by

a sterile tampon of gauze tightly packed in the vagina. This should be removed in from twelve to twenty-four hours. If there is then any tendency to hemorrhage and the os is still insufficiently dilated to admit the passage of the ovum, the tampon should be replaced. Should the ovum be found at this time it is generally true that the uterus is not empty but contains more or less membrane, or in the latter months the placenta. How shall these be obtained? Some of our text-books give one line of treatment for the specialist and suggest another for the general practitioner. This is not the question. Any general practitioner should be a specialist along this line. But are the surroundings such, is the assistance of the kind that will warrant the forcible removal of the uterine contents? If the finger can be introduced well into the womb, or better reach the fundus, by all means clean out the whole mass. The augur curette at times can be used to advantage. It is worth trying. Certainly any physician can be safely anti-septic with such tools. This ultra fear of touching a congested or open surface is carried to an extreme. As has been said, medicine has its surgical "dudes." The surgical side of our profession would do well if they did as little harm with their often carelessly and ignorantly used knife, as do the general practitioners with the much vaunted staphlococci and streptococci. Failing with these methods it must be a question decided by the particular needs of the case, as to whether curetting or other instrumentation is called for. Should this not be thought wise, the so-called expectant method can be followed. This consists in the use of sterile tampons and small repeated doses of ergot. If a temperature develops, the discharges become foul, or hemorrhages continue the uterus must be cleaned out. The after treatment is

practically nil unless some septic trouble develops or the general health needs attention.

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*CONSUMPTIVES IN COLORADO.*

BY W. T. LITTLE, M. D. CANON CITY.

The past few years have witnessed a movement in favor of the sanitarium treatment of pulmonary tuberculosis, that in certain sections of the East has amounted almost to a stampede. This movement had its inception in Europe, more particularly in Germany, where the results of institutional treatment under constant medical supervision have been so happy.

Prior to this time the medical profession of America had depended on climate alone to cure this dreaded malady, and that disappointment was the result is hardly to be wondered at.

It is not surprising, therefore, that the good results obtained by the well conducted sanitariums of Europe should appeal to us on this side of the Atlantic, and cause similar institutions to spring up in our populous eastern states where tuberculosis is so prevalent and so fatal.

But like so many reform movements in the past, when men in their enthusiasm have temporarily lost their judgment, so this sanitarium movement is apt to make some of its followers forget that there is, or ever was, any virtue in climate. In fact, some writers on the subject are already denying to climate any influence whatever.

No one has more faith in the modern sanitarium, and especially the modern sanitarium methods, than I; and were I to choose between a patient entering such an institution, situated though it may be on a New England upland with its rough and sunless climate, or shifting for himself in a cheap Colorado boarding house, I should choose New Eng-

land and the sanitarium. But if he can have the sanitarium methods together with the Colorado climate, I should unhesitatingly choose the latter.

From the earliest history of medicine, writers have mentioned the value of climate for tuberculosis, and Hippocrates advised consumptives to go to the mountains. Why to the mountains and not to the sea shore? Because in the mountains the air is not only pure, but there is less moisture and more sunshine. It is common observation of those who see consumptives, that they are depressed, cough more and feel worse on damp days. Why is it, you may ask, if Colorado climate is so beneficial, that you do not get better results? My reply is that our physicians are partly to blame. Those who practice in Denver, Colorado Springs and the valley towns see more cases of tuberculosis than any two other chronic diseases, and yet how careless, how indifferent are many to the needs of these sufferers.

A prominent physician in Colorado once told me that he hated to treat a case of consumption, for he was afraid of it. And yet he continued to accept as patients all who came to him. Could he do them justice? I think not. I have more than once had patients come to me with temperature ranging between 100° and 101° who were told by their former medical adviser to take daily horse-back rides or long walks..

It is the careful attention to these little things—the regulation of the daily life of the patient to the minutest details—that brings the favorable results in the sanitariums; and the same watchfulness is necessary here. Merely telling a patient to stay out of doors all he can, and to eat all he can will not do. He must be told what to eat and when to eat; how many hours a day to be out of doors, and how to ventilate his room at night.

Porch sleeping and tent life should be encouraged. He must be instructed as to how much exercise he may take, if any, and the kind of exercise; the care and disinfection of the sputa; and here I find too many physicians are careless or entirely negligent in failing to impress upon their patients the danger not only to others, but also to themselves, in re-infecting the already damaged lungs. Since the pocket sputum flask was brought to my attention, I have tried to have my patients use it, for I believe it is by far the cleanest method for ambulant consumptives. They usually object at first, but after talking about it every time I see them, they soon decide to use it. And I have not yet been told by any one using it that he did not find it a great comfort. It is the force of example that prompts all of us to do many things. If all physicians aimed to advise their tuberculous patients along the same lines—and it admits of no variations—we would often see them doing what they ought to do, without being told.

In spite of the fact that too many of our consumptives in Colorado drift along without a pilot at the helm, and sink when they might be saved, still many of them are finding the health they seek, while yet others are living lives prolonged by this beneficent climate.

I have analysed the records of 100 unselected cases seen in Canon City, and I find the results are very encouraging. All of these patients have been in Colorado more than six months, and many of them several years, so that the reported gains were not temporary. While 100 cases may not be enough to be convincing to some, I am satisfied it represents a fair average, taking them as they come.

Only ten of these sought a change of climate within the first three months of their disease. I date the beginning from the appearance of the first sign or symp-

tom observed by the patient. Three of these had the disease in an acute form. Four had one lung only affected, six had both; five were in the first stage, four were in the second stage, one was in the third stage. The results in these ten cases were as follows: Arrested, three, or 30 per cent; improved, two, or 20 per cent; failed, five, or 50 per cent. Of the four with one lung only affected, three improved; of the six with both affected, only two improved.

Between the third and sixth months, eighteen others had come to Colorado. Seven had but one lung affected, eleven had both lungs affected. Ten were in the first stage; five were in the second stage; three were in the third stage. The results were as follows: Arrested, four, or 22 per cent; improved, four; stationary, one; failed, nine, or 50 per cent. Of the seven with but one lung affected, five improved; while of the eleven with both affected, only three improved. Between the sixth and twelfth months of the disease twenty-two others came. Three had one lung only affected, nineteen had both lungs affected; seven were in the first stage; seven were in the second stage; eight were in the third stage. The results were as follows: Arrested, four, or 18 per cent; improved, one; stationary, four; failed, thirteen, or 59 per cent. Of the three with one lung affected, two improved; while of the nineteen with both affected, only three improved, but the disease was arrested in all of these.

The remaining afflicted ones came to Colorado any time between one and ten years after the onset of the disease.

Of the total number of cases when observed by me, one lung only was affected in twenty-seven; both in seventy-three. The final results were as follows: Of those with one lung only affected, nineteen improved, or 70 per cent; failed,

seven; no record, one. Of those with both lungs affected, eighteen improved, or twenty-five per cent; failed, fifty-one; no record, four.

The results obtained at some of the leading sanitaria (I have taken my figures from Knopf's work<sup>1</sup> published in 1899) are as follows: Loomis Sanitarium, cures, 25 per cent; improved, 50 per cent. Adirondack Cottage Sanitarium, cures, 20 to 25 per cent; improved, 30 to 35 per cent. These two admit only incipient cases. Winyah Sanitarium at Ashville, cures, 26½ per cent; improved, 42½ per cent. Falkenstein, Germany, cures, 14 per cent; improved, 59 per cent. Davosplatz, Switzerland, cures, 40 per cent; improved, 40 per cent. These three do not receive advanced or incurable cases. It was seen that 70 of my patients improved when but one lung was affected. In 26 per cent of these the disease was arrested.

This classification of cases will probably fairly represent the class treated at the sanitaria, so you see the results are about the same. At Davosplatz the results as published were the best, for there 80 per cent improved, and half of these were cures. The climate of Davos, however, more nearly approaches that of Colorado than does that of any of the other resorts mentioned. We Coloradans know what a dumping ground our state has been for the consumptives of the East. No examination for admission has been required; and I feel confident that 50 per cent of those who come here could not get into any of the closed establishments of Europe and America. Is it to be wondered at that hundreds of these sufferers have been disappointed and have returned home to die, while physicians and friends alike have decided that the curative power of Colorado climate is a myth?

I have alluded, in the first part of this paper, to the responsibility resting upon

our own physicians in properly caring for these patients after they come to us. Just as great responsibility rests with their home physicians who send them here. Of greater importance than the early diagnosis of the disease is the character of the advice given. The physician should be truthful and honest. He should not deceive his patient by withholding from him a knowledge of his exact condition. Let him be told at once that he has consumption. It may be a temporary shock, but he will respect his advisor for telling the truth. Then let it be explained to him that tuberculosis is one of the most curable of all diseases, but that he must be treated all the time until he is well. Now the patient understands his condition and will appreciate the importance of all the advice given him, which he will not do if the truth is withheld at the beginning.

Next I would suggest to our eastern brother that he be not influenced by the query of his patient who may not fancy the idea of leaving his home and business, if tonic treatment and a few weeks' rest will not restore him to health. He should be told immediate change is an absolute necessity, but consider carefully where to send him.

Portes<sup>2</sup> classifies certain tuberculous subjects as undisciplined, vacillating and solitary. The undisciplined are those who heed nothing but their caprices and range from one fashionable climatic resort to another, disregarding medical advice. The vacillating are those who prefer the advice of their friends to that of their physician, and try one remedy after another. The solitary are those who remain suffocating and moping in an overheated, close room, with no appetite or distractions, and when they go out, walk until they are exhausted. The sanitarium, he says, is absolutely necessary for these three classes of patients. If, then, your patient belongs to one of these

classes, do not send him to Colorado, but to one of the closed establishments in the East.

I would add to these three classes a fourth class—the poor. Many of the state and municipal governments are providing sanitariaums and camps for this class of consumptives, where for a nominal cost, and in some instances without cost, they can receive excellent care near their homes. More than once have I been called to a sick bed to find a man dying of consumption, with the flush of fever on his sunken cheek, his emaciated body racked with the torments of an incessant cough, hoping against hope. His faithful wife tells me her husband has been sick for two or three years, but remained at home under the doctor's care. As a last resort she was advised to bring him to Colorado, which she had done at great sacrifice; but the expected relief had not come. The physician who advises or consents to a man or woman in that condition leaving the comforts of home to come here is unworthy of his profession. And still hundreds of such come to Colorado every year, their lives shortened by the hardships they are forced to endure.

If, however, the patient belongs to that large class that will find the life of a sanitarium irksome and monotonous; who is in moderately easy financial circumstances so that the expense of a year or two away from home will not be burdensome; and is reasonable, sensible and willing to follow advice; then Colorado offers every advantage that an ideal climate possesses, viz.: Dry, pure air, abundance of sunshine, a temperature that admits of comfortable tent life the year round, together with opportunities for carrying out the same careful regime found at the best sanitariaums.

<sup>1</sup>S. A. Knopf, Prophylaxis and Treatment of Pulmonary Tuberculosis, 1899.

<sup>2</sup>Porte's Journal de Med. de Bordeaux.

#### COUNTY MEDICAL SOCIETIES.

**Denver.**—The meeting of April 5 was devoted to a **Symposium on Medical Laws.** The Hon. I. B. Melville, Assistant Attorney General for the State of Colorado, took up the **relations of osteopathy to the medical laws** of the state. He pointed out that the constitutional provisions protecting the freedom of the individual in the enjoyment of his religious beliefs, did not extend to any practice that would injure his neighbor, or militate against the general welfare. He instanced the case of the Mormon Church and the practice of polygamy. In this way, while a man might practice whatever system of medicine he might prefer, and while people of mature minds might choose any system, such practice must be carried on under restrictions that would prevent harm to others or to the community at large. Protection must, also, be given by the state to the immature and helpless.

To these ends the general police powers of the state permit laws requiring a certain standard of qualification for those engaging in the practice of medicine. The osteopaths, while constantly proclaiming in public and in the lobbies of the legislature, that medical laws were especially aimed at them, when proceeded against for the illegal practice of medicine, had set up the claim that the practice of medicine consisted entirely in the giving of drugs; and that, therefore, medical laws did not apply to them at all, because they gave no drugs. This contention had received some support in one of the lower courts, but it was opposed by the bulk of decisions in other states, and by the two decisions that had been rendered by the Supreme Court of this state with reference to the Medical Practice Act of Colorado.

In the case of Mrs. Harding, an electropath, who undertook to practice after failing to obtain the license of the State Board of Medical Examiners, the lower court decided that the Medical Practice Act prohibited her from engaging in her peculiar system of practice without such license; and the Supreme Court upheld the decision. In the other case a certain Brown assumed the title of M. D., was convicted of illegal practice, and the decision of the lower court affirmed.

Mr. Melville pointed out how the recent verdict against the State Board of Medical Examiners, and in favor of an osteopath, had been reached through the ruling of Judge Mullins. Before taking action against the

osteopath, Dr. Van Meter had consulted several leading lawyers who had agreed that "Dr." Bass was violating the medical law. He then took the matter to the District Attorney, who concurred in this view, had informations drawn, and commenced proceedings to vindicate the law. These were quashed by the judge before whom the matter was brought. Then Dr. Bass sued Dr. Van Meter and the State Board of Examiners for damages for malicious prosecution. Although the law and universal practice everywhere protect a citizen from any such suit on account of actions brought through the public prosecutor, Judge Mullins ruled that the Board of Medical Examiners were liable for damages on this account. It had been hoped that through this case a ruling of the Supreme Court might be obtained, defining the relation of the Medical Practice Law of Colorado to the practice of osteopathy. But the trial in question was so full of errors, that the verdict was likely to be set aside without this important point being touched upon.

Hon. H. E. Kelley, Counsellor for the Colorado Medical Legislative League, believed there were only two great professions; the medical and legal, and from the experience of the latter he drew some lessons bearing upon the need of organization in the medical profession. The Colorado Bar Association, although it did not include by any means all the lawyers in the state, nor have the support of any especial law, was a body of such standing force and activity, that it practically compelled honesty and decency on the part of all who would practice law in Colorado. Even in regard to the conduct of a legal case, there would be as many opinions as there were lawyers. Some yielding was always necessary. To get any efficient medical law, individual ideas and preferences must be sacrificed. All could agree on the common ground of requiring a searching scientific education of all who would practice medicine. Those best fitted should be chosen to consider the situation, and the most practical law to meet it; and then the loyal support of the whole profession should be given to this measure, and to aid those working for it.

He pointed out that when the Sanford bill was before the governor last year, prominent and generally respected physicians had advised him to veto it. There was lack of unity on the part of the medical profession. The first need was to instruct and convert some of the

doctors. Then the subject must be explained to the public. When this was done there would be no difficulty in getting popular support for such measures. In spite of all that is said, the profession is held by the general public responsible for the public health. The medical profession had plenty of influence, if it would unite and use it.

Dr. W. W. Grant, President of the Colorado Medical Legislative League, wished to point out that there were certain things the profession of Colorado were not responsible for. That they were not responsible for Judge Mullins, or for two governors that had vetoed excellent medical laws.

He referred to the Colorado plan of organization, and the unanimous approval of it by the National Council on Medical Legislation; and read an editorial from the Journal of the American Medical Association, supporting that plan. The medical profession must fight unqualified practitioners; and it must fight the politicians who support unqualified practitioners. No self respecting medical man could vote for one who would degrade our profession to the level of the quacks.

Dr. Edward Jackson said that the effort to define the practice of medicine was an effort to prevent the taking of money by false pretense. Through the work of an educated body of practitioners the words "Doctor of Medicine," and "Medical Practice," had come to have a certain significance. To prevent the application of these words to those who did not possess the same qualifications, was an effort to check misrepresentation and falsehood. The first step of the quack was to assume the title of Dr., and give out that he was engaged in some kind of medical practice. No one, doctor or lawman, could afford to assist this form of misrepresentation and falsehood.

Dr. S. D. Van Meter called attention to the report of the committee appointed by the National Legislative Council to draft a form of Medical Practice Act, that should serve as a model in all the different states, and with only such modifications as were necessary to meet the different state constitutions, should be recommended for universal adoption. He showed a certificate of death by tuberculosis signed by an osteopath, that had been presented at the office of the Denver Health Commissioner.

He wished to point out that the fight was not against osteopathy especially; but against all of those who, professing some new school

or cult of medicine, sought through it to evade the laws regulating medical practice. There were sixteen such cults or pathies now in existence in this country, and others liable to spring up at any time. The fight was not against the osteopath, but against any "path."

Upon motion of Dr. J. M. Blaine, the thanks of the Society were extended to Mr. Melville and Mr. Kelly for their addresses.

**The Otero County Society** met at La Junta April 12. The papers were by R. F. Sigman, Rocky Ford, "Streptolytic Serum in Pulmonary Tuberculosis with Mixed Infection;" and Dr. Wm. Moore, La Junta, "The Practice of Medicine in Cyprus and Syria."

It was voted to proceed with the prosecution of S. W. Billingsea, of La Junta, for advertising with the title of "M. D." after his name, without being registered; also W. H. Easter, of Rocky Ford, for distributing circulars signed "Dr."

It was decided to request the newspapers of the county to refrain from mentioning the name of any member of the Association in connection with news items of sickness or accident.

Members present: Moody, of Fowler; Kearby, Sigman and Myer, of Rocky Ford; and Finney, A. L. Stubbs, Jessie Stubbs, Kearns, Donlon, Ragsdale, Moore and Edwards, all of La Junta. E. GARD EDWARDS, Secretary.

#### OTHER MEDICAL SOCIETIES.

**Denver Clinical and Pathological Society.**—At the regular meeting, April 8, Dr. Grant exhibited Specimens (1) an appendix, removed from a boy of 12 years, which was gangrenous and was accompanied by a post-cecal abscess. (2) Pustule removed intact with ovary.

Dr. Delehanty reported a case of double **facial paralysis** in a male of 27 years, accompanied by constant headaches. Under treatment with the salicylates recovery took place.

Dr. Freeman discussed the operative treatment for **fracture of the neck of the femur**, by nailing the fragments. He considered the operation unadvisable in recent cases, but deemed it applicable in un-united fractures in young adults.

Dr. Black discussed the frequency of the **recurrence of adenoids** in cases where tonsillectomy was not done at the time of the removal of the adenoids. He cited three cases which led him to suggest this.

Dr. Hill reported a case of **clavus** in a male suffering from gonorrhea and stricture, the passage of a sound intensifying the head pain.

Dr. Lyman reported a case of **fractured pa-**

**tella** operated after the subsidence of the acute inflammation. The fragments were wired.

Dr. Pershing reported three cases of **optic neuritis with headache**: (1) supposed to be syphilitic, treated with iodid of mercury—recovery; (2) and (3) caused by cerebral tumors, treated with mercury and potassium iodid, some improvement following.

Dr. Hall made a further report on four cases of pernicious anemia. Two had relapsed and two remained well.

Dr. Jackson discussed the recent epidemic of acute conjunctivitis due to the diplo-bacillus of Morax and Axenfeld. The symptoms were in direct proportion to the number of the bacilli found in the conjunctival discharge. Members present, 30; visitors, 2.

F. W. KENNEY, Secretary.

#### BOOKS.

**Mechanotherapy and Physical Education**, including Massage and Exercise, by John K. Mitchell, M. D., Physician to Philadelphia Orthopedic Hospital and Infirmary of Nervous Diseases; and **Physical Education by Muscular Exercise**, by Luther Halsey Gulick, M. D., Director of Physical Training in the Public Schools of Greater New York. Philadelphia, P. Blakiston's Son & Company. 1904.

This volume of 420 pages, with 229 illustrations, is scheduled as Vol. VII of Cohen's System of Physiologic Therapeutics. It is, however, the 10th of the series to appear; the volume yet to come dealing with Radio-Therapy, Sero-Therapy, etc.

It contains special chapters on Orthopedic Apparatus by James K. Young, M. D.; Corrective Manipulations in Orthopedic Surgery, by H. A. Wilson, M. D.; and Physical Methods in Ophthalmic Therapeutics, by Walter L'Pyle, M. D.

As a correction of the tendency toward mere drug giving, which is apt to beset the practitioner, the reading of this system will have the highest value; and no volume in the series affords more practical hints of every-day usefulness than this one on exercise, massage and manipulations. It is truly a work on therapeutics, constantly directed toward its object, the relief and cure of patients. But it brings to this task a broader range of resource than the older physicians could command. The illustrations are particularly valuable. They explain movements, manipulations and apparatus better than could possibly be done by verbal descriptions.

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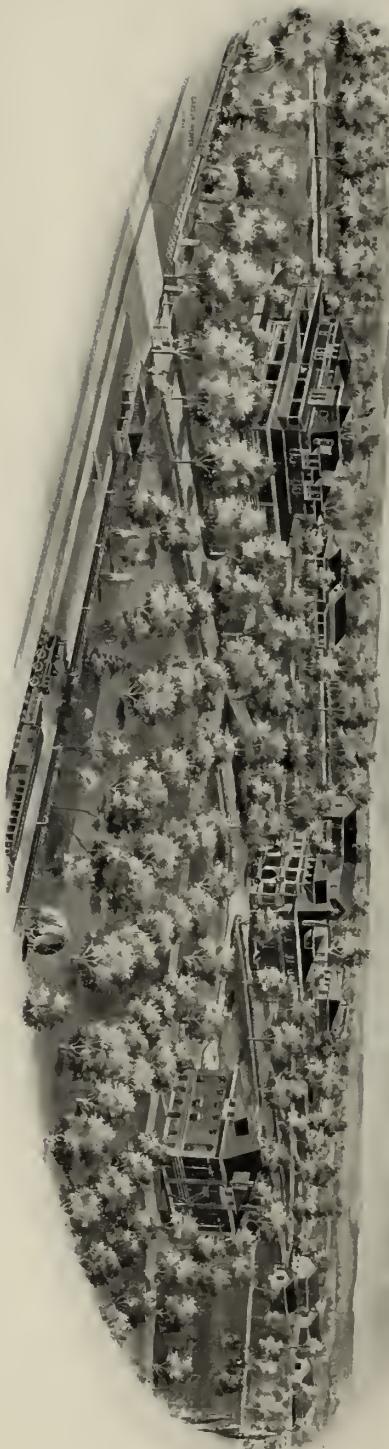
### MEDICAL MEETINGS FOR 1904.

#### SOCIETY.

#### PLACE.

#### TIME.

American Medical Association.....	Atlantic City .....	June 7-10, 1904.
Secretary, Geo. H. Simmons, 103 Dearborn Ave., Chicago.		
Colorado State Medical Society.....	Denver .....	October 4-6, 1904.
Secretary, J. M. Blaine, Steele Block, Denver.		
Idaho State Medical Society.....	Lewiston .....	October 6-7, 1904.
Secretary, Ed. E. Maxey, Boise, Idaho.		
Wyoming State Medical Society.....	Rawlins .....	September 13, 1904.
Secretary, H. S. Finney, Rawlins.		
American Academy of Ophthalmology and Oto-Laryngology.....	Denver .....	August 24-26, 1904.
Secretary, D. T. Vail, 4 W. Seventh St., Cincinnati, Ohio.		
Rocky Mountain Interstate Medical Society.....	Denver .....	September 6-7, 1904.
Secretary, Geo. A. Moleen, 316 Mack Block, Denver.		



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